Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $103.00 for date of service 04/05/01.

   b. The request was received on 02/08/02.

II. EXHIBITS

a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/11/02
b. HCFA(s)-1500
c. TWCC 62 forms/Medical Audit summary dated 02/04/02
d. Medical Records
e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution dated 04/30/02
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/26/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/26/02. The response from the insurance carrier was received in the Division on 04/30/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 04/11/02:
   "The Documentation [sic] submitted substantiates the care given and the need for further treatment(s) and/or service(s), if applicable it also indicates progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected outcomes."

2. Respondent: Letter dated 04/30/02:
   "The requester did not document a comprehensive history or comprehensive examination. The requester did not document a history of present illness, review of systems, or past family and/or social history. The requester did not document ANY

physical examination of the right wrist and did not document a comprehensive examination of the left wrist….It is the position the requester's documentation does not support reimbursement for a 99215 level office visit…"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 04/05/01.

2. The provider billed a total of $140.00 on the date of service in dispute.

3. The carrier did not reimburse the carrier for the service billed. The amount in dispute per the TWCC 60 is $103.00.

4. The EOB denial is "COD1 – F - T,N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED." A medical audit dated 02/04/02 states, "Reimbursement is denied for the service billed as the documentation submitted does not support the specific level of service billed…"

5. The carrier's response is timely. No other EOB(s) or re-audits were noted. The Medical Review Division's decision is rendered based on denial codes submitted to the provider prior to this dispute being filed.

6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
04/05/01	99215	$140.00	$0.00	F,T,N	$103.00	STG Rule 134.1002 (e) (2) (A) (i), (e) (3) (B); MFG E/M GR (IV) (A), (C) (2); CPT descriptor	Per the STG, "…treatment of a work related injury must be: (i) adequately documented;….Documentation shall be provided by the health care provider to determine the level of care to be provided…" The MFG E/M states, "The level of E/M services encompass the wide variations in skill, time, responsibility, and medical knowledge required for the diagnosis and treatment of illness or injury and the promotion of optimal health…**TWO OF THE THREE KEY COMPONENTS** (as set out in the descriptors) shall meet or exceed the stated requirements to qualify for a particular level of E/M service: …office, new patient, hospital observation services; initial hospital care; office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care; new patient; and home, new patient." CPT descriptor 99215 states, "Office or other outpatient visit for the evaluation and management

							Of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient(s) and/o family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family." The provider failed to meet the criteria of the descriptor of CPT code 99215 in the 04/05/01 report by not including a comprehensive examination or a comprehensive history. The provider included in the dispute packet a "NEW PATIENT MEDICAL INFORMATION" form dated 02-06-01. **No** reimbursement is recommended.
Totals		$140.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 22nd day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.